

CSTAR TRANSITIONAL HOUSING REQUESTS AFTER THIRD MONTH

**WORKSHEET MUST BE COMPLETED IN ITS ENTIRETY OR REQUEST WILL NOT BE PROCESSED
FAX TO (573) 751-9296**

Client Name _____ Admission Date _____ Marital Status _____

Are children living with client? Yes _____ No _____ If not, where? _____

Ages of children in client's physical custody _____

Place of Employment	Date Started	Monthly Gross Income

Other Sources of Income _____ Amount \$ _____

Seeking employment? Yes ☐ No ☐ If no, why not? _____

REQUEST:

Transitional Housing Name or Community Housing Address _____

Amount of Rent \$ _____ Amount of Request \$ _____ Client Will Contribute \$ _____

Client's Contribution to Date \$ _____

Is this last month housing dollars will be requested? Yes ☐ No ☐ When will be last month? _____

HOUSING:

Client homeless upon admission? Yes ☐ No ☐ Date housing identified as a need _____

Date of first Community Support note addressing housing need _____

Housing Program	Application Date	Status of Application
Housing Authority:		
-- <i>Section 8</i>	_____	_____
-- <i>Public Housing/ Community Action Agency</i>	_____	_____
-- <i>Family Self-Sufficiency Program (K.C. – St. Louis – Springfield)</i>	_____	_____
DMH Housing Staff:		
-- <i>Shelter Care Plus</i>	_____	_____
-- <i>Rental Assistance Program</i>	_____	_____
Other: _____	_____	_____

Other Justifying Information _____

Does client continue to meet all requirements for transitional/community housing? Yes ☐ No ☐

Worksheet Completed By _____ Date Completed _____